MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Edward Wolski, M.D. / Wol+Med 2436 I-35 South, Ste. 336 Denton TX 75205	MDR Tracking No.: M4-03-8862-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 19 Fidelity & Guaranty Ins. / Flahive Ogden & Latson PO Box 1367 Austin TX 78711	Date of Injury: Employer's Name: Performance Transportation Serv. Insurance Carrier's No.: 4650158352

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
9/5/02	9/5/02	97545-WC	$118.00	$72.00

PART III: REQUESTOR'S POSITION SUMMARY

1/14/04: "…Our Position: For DOS 9/5/02 - The carrier failed to reimburse… The carrier initially failed to respond to our initial billing…carrier failed to respond to our request for reconsideration…."

PART IV: RESPONDENT'S POSITION SUMMARY

1/12/04: Respondent marked on the Table of Disputed Services: "Carrier did reimburse per applicable guideline and carrier did respond to requestors reconsideration as per the TWCC-62 the Requestor attached dated 5/23/03."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- On 7/24/03, MDR received the Requestor's request for reimbursement of treatment/services rendered on DOS 9/5/03 to the injured worker.
- The Respondent did not provide the first EOB's or payment history or explanation to allow the sender to understand the reason for the lack of payment according to Rule 133.307 (e)(2)(B) for the DOS in dispute. The Respondent did point out the Requestor did receive the 'reconsideration response' as the Requestor attached it in their request for MDR, dated 5/23/03.
- After review of the information received from the Requestor and Respondent, the following conclusions have been determined:
    1) The Requestor provided convincing evidence that the HCFA's were submitted for reimbursement and reconsideration to the Respondent according to 133.304(k).
    2) The Respondent did not submit the first EOB, therefore unknown if payment was made according to the MFG/MGR (II)(D), reimbursement is recommended.

DOS: 9/5/03 CPT 97545-WC $36.00 x 2 units= **$72.00**

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $72.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

		6/23/05
Authorized Signature	Name	Date of Order

PART V: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, PO Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____